MDPB Minutes September 15, 1999

Members present: R. Chagrasulis, E. Smith, J. Burton, P. Liebow, D. Stuchiner, H. Grimmnitz
MEMS Staff: J. Bradshaw
Regional Coordinators: J. LeBrun
Guests: Dan Palladino, Bill Dunwoody, Jeff Regis

Item	Discussion	Action	Follow-up
Previous minutes: June 16, 1999	None	Adopted	
Old Business I. Medical Direction	I. A. Medical Direction 1) Definition: a. Medical Direction may be "Direct Medical Control" (on-line or immediate) or "Indirect Medical Control" (off-line). Direct Medical Control is the contemporaneous physician direction of a field provider. This communication may be via radio, telephone, or actual contact with a physician on-scene. Indirect Medical Control refers to all aspects of medical oversight which are not direct. This would include (but not be limited to) establishment of prehospital patient care protocols, interaction with operational and administrative aspects of EMS, education and training, quality improvement, ambulance staffing, dispatch issues, and hospital destination. b. MEMS Rules Definition:(2A.18) Medical **Direction** is physician supervision of prehospital emergency care. More specifically, it is **those actions taken** to ensure that care **provided** on behalf of ill or injured patients is medically appropriate. **This would include (but**	I.A. 1) Definition of Medical Direction Jay Bradshaw to incorporate into proposed Rules changes consideration by the Board of MEMS. 2) Where do we go from here? a. Develop "Mission Statement" which describes and defines the over-all purpose of Medical Direction and OLMC (E.g., ...to provide medically appropriate patient care on behalf of ill or injured patients....to provide appropriate contemporaneous physician direction to field providers, including knowledge and understanding of prehospital protocols...) b. Review data and literature available on provision of OLMC. Who provides, does level of training have any effect, does direct OLMC have any measureable impact on patient care outcomes, etc.	I.A.1. Definition of Medical Direction to be referred to Board of MEMS. 2. Burton/Smith to collate literature for review at next meeting on provision of Direct OLMC.

not be limited to) establishment of prehospital patient care protocols, interaction with operational and administrative aspects of EMS, education and training, quality improvement, ambulance staffing, dispatch issues, and hospital destination.

a. Direct Medical Control (on-line or immediate medical control):

i. The contemporaneous physician direction of a field provider utilizing radio or telephone, or actual contact with a physician on scene.

ii. This physician direction may be provided by medical personnel delegated by the physician(s) charged with medical oversight. *

b. Indirect medical control is the administrative medical direction of EMS personnel by a physician as designated by 14 (D) of these rules.

* This situation, who gives direct medical control, and whether any direct medical control is beneficial, needs further review by the MDPB. (See below)

2) Where do we go from here?

Who should provide direct medical control? How do we deal with lack of understanding by medical control providers of our EMS system and protocols?

The “playing field” of MCP’s needs to be levelled. Basic information and education should be consistent and standardized; all MCP’s should have knowledge and understanding of

I. B. Certification/Recertification /Decertification	prehospital protocols. Should the "bar be raised" for provision of on-line medical control in terms of who is allowed to provide such OLMC? I. B. Certification: Previous re-engineering discussion and follow-up meeting with MEMS staff, ops team members, and MDPB led to a conceptual model which has never been implemented. Current proposed MEMS Rules changes would allow this model to be adopted. (e.g., consistency of all regions with initial licensure "certification" process, eliminating "stickering", same process applies to all levels of providers, etc). Recertification: Ongoing development. Ops team working on recert process as piloted by Tri-county within various regions. Decertification: Previous meetings and discussions led to certain questions which needed AG input. Questions sent to AG but no response.	I. B. Certification: Jay Bradshaw, Chag, and Joanne LeBrun to summarize previous discussions, develop proposed certification process to present to MDPB at November meeting. Refer this proposed process to Ops team for review. Develop proposed implementation plan. Recertification: No new action needed. Decertification: Jay Bradshaw, Drexell White, Chag to summarize previous discussions on Decert; re-submit questions to AG.	I. Cert: Report at next meeting. Decert: Report at next meeting.
New Business A. IO Study- Dr. Burton B. Central Line Training	A. Dr. Burton presented "An EMS Pilot Program for Utilization of a Sternal Intraosseous Device in Adult, Non-traumatic, Cardiac Arrest Patients". This is an FDA-approved device. Phase I would be a 6 month program in which the initial IV attempt would be peripheral. If that attempt failed, the provider would use sternal IO access. In Phase II, the IO device would be used for 1st line vascular access.	A. The MDPB approved this as a pilot program. Phase I results, however, should be reported after the initial 6 mo. period, prior to starting Phase II.	Chagrasulis to report adoption of this as a pilot study to the Board of MEMS. Dr. Burton to report in 6 months after initiation of the study.

	B. Dan Palladino CCEMT-P, Delta, presented proposed curriculum for "Central Line Access of Paramedics", as well as implementation plan. The MDPB felt this was an excellent outline, and approved it for statewide use with the following provisios: 1) Paramedic level only, 2) Add to the curriculum a summary and discussion of the situations in which such prehospital access would be appropriate (eg, volume resusitation, medications clearly needed vs. routine situations, etc.), 3) MDPB guidelines for appropriate training will be published such that training for central venous access should be by hospital-based RN's who are currently credentialled for such devices, and who also currently instruct others in the insertion and access of such devices, and who are approved for such training of prehospital providers by the regional office. Ideally, the training would be by a team consisting of such an RN, in addition to a paramedic already trained (and who is approved by the regional office to participate in this training).	B. 1) Chag to write a letter to hospitals (Nursing departments, ED directors, Critical Care committees) explaining the addition of this Central Line Training to paramedic prehospital care. 2) Chag to refer this curriculum and MDPB guidelines to the education committee for their review. 3) Jay to check for any other implementation issues. 4) Dan to check with Jay prior to implementation to make sure these issues have been addressed	B. QA follow-up for appropriateness of use in 6 months after use begins.
Protocols		Implementation date Nov 1	
Other: 12 Lead EKG by EMT-I on MDI - Dr. Liebow	Dr. Liebow presented a proposal by Mount Desert Island for EMT-I to utilize 12 lead technology in the field. The rationale is that 1) Paramedic level generally not available, 2) such access to 12 leads would improve "door to drug" time for thrombolytics, 3) EMT-I would obtain but not interpret such EKG's, 4) CQI review would ensure no significant increase in transport of on scene time, 5)	MDPB approved this proposal for pilot project.	Annual review of date should report 1) Review of door to drug time for thrombolytics, 2) on scene and transport times.

	Dispatch patterns for ALS back-up would not change.		
Tabled items: 1) Alternative Health Care Facilities - Definition 2) CQI - review regional plans/ establish statewide indicators 3) Jackman Area Health Center - use of PA's in prehospital care 4) Transfer of care protocol			
Next meeting	Next meeting to address CQI issues Also, report on proposed rules changes by MEMS.	Jay to send letter to regional coordinators about CQI, asking them to present a brief summary of CQI plan within their region. No meeting in October; next meeting scheduled for November 17 Also, MDPB members reminded that the Samoset conference is scheduled for the second weekend in November with the MDPB forum being on Saturday Nov 13 at 8:30 am.	
Implementation Issues		✓ 1) Refer MDPB suggested changes to Rules definition of Medical Direction (Control) to Board of MEMS - Jay ✓ Develop proposal for initial certification of EMT's for review at Nov meeting - Jay, Chag, LeBrun	

		✓ Review past questions sent to AG on Decert issues, and resubmit to AG - Jay, Chag, Drexell ✓ Refer approval of “IO Study” as pilot to Board of MEMS - Chag ✓ Refer approval Central Line Training plus guidelines for training to Education committee and Board of MEMS; publish guidelines and send letter to hospitals - Chag ✓ Send letter prior to Nov. meeting to regional coordinators asking for their input on CQI, and review of regional CQI plans at next meeting. - Jay ✓ Refer to Board of MEMS the MDPB approval of use of EKG by EMT-I on Mount Desert Island as pilot program - Chag	